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ABSTRACT

Collaboration between health and education providers is essential to address the urgent needs of children and families most at risk of school failure and severe health problems. Collaboration represents a fundamental change in the way education and health systems think about, identify, and meet the needs of children, youth, and families utilizing a holistic approach. This report, organized into five sections, sets the stage for action. The first section looks at policy issues of health/education collaboration, including strategies to clear the hurdles that are in its path; issues of funding; the appropriate role of state and federal governments; and specific issues involving programs aimed at infants, toddlers, preschool children, and school-age children. The next three sections provide examples of health/education collaboration at the state, local, and federal levels. The final section presents an annotated bibliography of useful sources for policymakers and providers concerned with health and education collaboration. Collaboration is not an end in itself but a means to an end; it is a process, rather than a product; and policymakers must provide incentives for collaboration, resources to fund collaborative initiatives, and support for front-line providers at all levels. (LL)

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CREATING SOUND MINDS AND BODIES:

HEALTH AND EDUCATION WORKING TOGETHER

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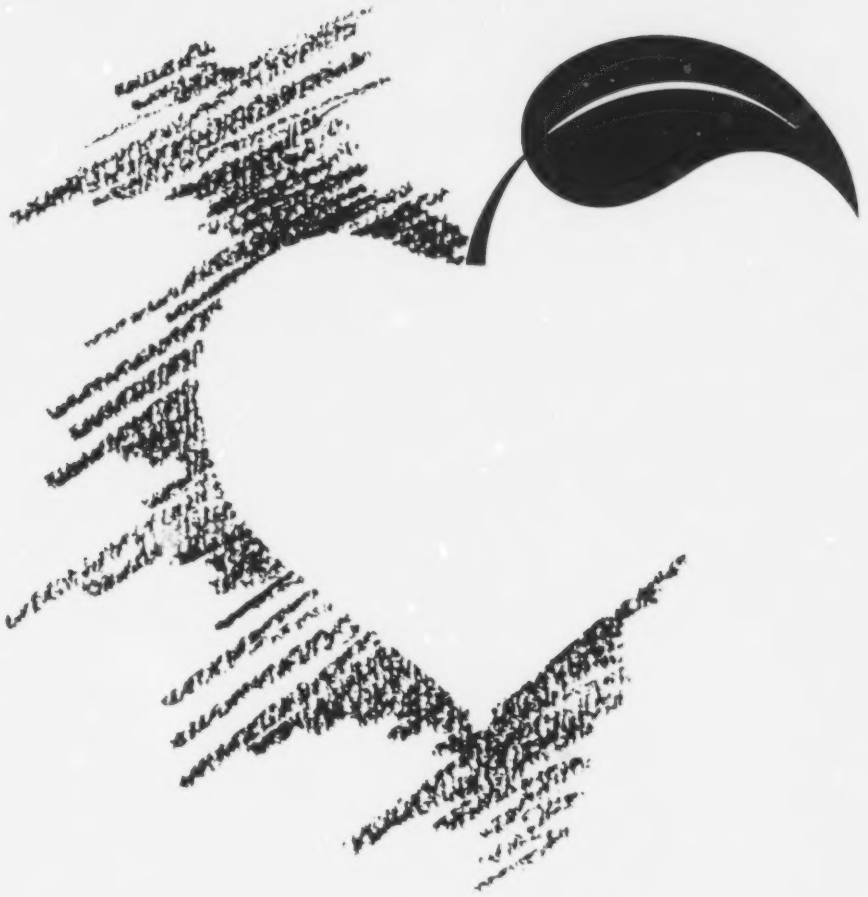

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The National Health/Education Consortium (NHEC) is a joint effort of the Institute for Educational Leadership and the National Commission to Prevent Infant Mortality.

NHEC acknowledges with appreciation the Prudential Foundation for its interest in promoting health/education collaboration. By underwriting the creation of the Consortium and many of its publications, the Foundation has helped to further greater public understanding of the critical linkage that exists between the health of a child and his or her potential to learn.

THE CHALLENGE

CONSIDER THESE FACTS FACING OUR SOCIETY:

- Forty thousand American babies die before their first birthday. Nearly 271,000 low birthweight babies are born each year, a condition which can lead to a variety of physical and learning disabilities that handicap a child for life.[1]
- Adequate prenatal care, which can prevent infant death and low birthweight, can cost as little as $500 per mother. The cost of providing lifetime services to a child born to a mother who did not receive adequate prenatal care can reach $500,000.[2]
- One reliable estimate puts the number of babies born exposed to all types of illegal drugs at 375,000 a year. If this is true, the cost to ready such infants for school could be in excess of $15 billion annually.[3]
- One American child in six has toxic levels of lead in his or her blood. Adverse effects of lead in children include decreased intelligence, developmental delays, and behavioral problems. If lead poisoning were prevented, the estimated savings in special education costs would be $3,331 per child.[4]

The crisis of inadequate services for disadvantaged children and families in America is all too familiar. Our health care and education systems face serious challenges, and increasingly, health care providers, educators, and policymakers realize that none of us can effectively tackle the problems alone.

Collaboration between health and education providers is essential to address the urgent needs of the children and families of this nation, particularly those who are most at risk of school failure and severe health problems.

Collaboration between health and education could revitalize service systems designed for a different time. Millions of children and their families need effective and appropriate services. Currently, one-third of American women do not receive adequate prenatal care; their children are at greater risk of developmental and health problems throughout their lives. Vast numbers of drug-affected babies—

estimated at 375,000 per year—are challenging the health care and education systems with new and pressing needs. More than 36 million Americans do not have health insurance; 59 percent of them are working or live in families where someone is employed. About seven million children do not receive the periodic health screenings and immunizations that could help them avoid future health problems. One-third of the children enrolled in special education programs would not have disabilities or would have less severe ones if medical care during pregnancy and the first year of life had been adequate.

These disturbing facts need not lead to hopelessness. Research and practice show that appropriate attention to a child's environment can offset the consequences of such neglects as inadequate prenatal care or in-utero drug exposure.

"Initial stages of neurological development can dramatically influence a child's life options and possibilities," writes the NATIONAL HEALTH/EDUCATION CONSORTIUM, a collaboration of 51 national health and education organizations representing nearly 11million individuals. "At life's beginning, the brain's potential can be enhanced or hindered by the child's environment," including the health care and nutrition of the mother during pregnancy and the physical and psychological nurturing available to the child.

The Consortium also notes that several successful programs and studies demonstrate that "'at-risk' does not mean 'doomed.'"

Data from one major study show a long-term impact of early intervention, through 12 years of age, on achievement in reading, math and retention.[5] Another study indicates that early intervention could prevent intergenerational illiteracy in children whose mothers had particular difficulty in school themselves.[6] Studies such as these reinforce the fact that effective collaboration and intervention CAN make a difference.

In the fall of 1989 the President and governors tied health and education together as they embarked on an effort to achieve the National Education Goals. These two communities of interest affect all of us, at no matter what socio-economic level. If we reform one without the other, our nation will ultimately fall short of achieving those goals. In particular, if all children in America are to start school ready to learn by the year 2000, as the first goal states, they must also start school healthy. This requires collaboration between the health and education systems. Children without appropriate health care, born to mothers without adequate prenatal care, will simply be unable to fulfill their learning potential, despite the best-intentioned efforts to reform the education system.

Current trends are encouraging. At all levels—in Washington, D.C., statehouses nationwide, and local communities from New York City to San Diego—collaboration is taking hold. However, though we know WHY we need to collaborate, we are still not certain HOW to successfully implement and sustain collaborative efforts. It is now time to act on what we do know.

This report sets the stage for action. It offers information for those seeking some answers on why and how. The first section looks at the policy issues of health/education collaboration, including strategies to clear the hurdles that are in the path; issues on funding such efforts; the appropriate role of state and federal governments; and specific issues involving programs aimed at infants, toddlers, preschool children, and school-age children. The second section provides examples of health/education collaboration at the state, local, and federal levels. The third section presents an annotated bibliography of useful sources for policymakers and providers concerned with health and education collaboration.

[5] U.S. Department of Health and Human Services, National Center for Health Statistics (November 28, 1990). "Births, Marriages, Divorces, and Deaths," *Monthly Vital Statistics Report* 39, (7):1.

[6] National Commission to Prevent Infant Mortality (1990). *Troubling Trends: The Health of America's Next Generation*. Washington, D.C.

[7] Center for Demographic Policy (June 1991). "Drugs and Babies: What lurks ahead for the health, education and legal systems?," *Center for Demographic Policy Newsletter*, Vol. 2, No. 3: 2-3.

[8] U.S. Department of Health and Human Services, Public Health Services (1991). *Strategic Plan for the Elimination of Childhood Lead Poisoning*. Washington, D.C.

[9] Ramey, C.T., Campbell, F.A., Burchinal, M., Sparling, J. (in press). "Early Intervention Produces Long-lasting Cognitive Achievement and Reduces School Failure," *Proceedings of the Working Conference on New Directions in Child and Family Research: Shaping Head Start in the '90's*, June 24-26, 1991, Arlington, VA.

[10] Martin, S.L., Ramey, C.T., and Ramey, S.L. (1990). "The Prevention of Intellectual Impairment in Children of Impoverished Families: Findings of a Randomized Trial of Educational Day Care," *American Journal of Public Health*, Vol. 80:844-847.

Moving From Agreement To Action

At its broadest level, collaboration represents a fundamental change in the way education and health systems think about, identify and meet the needs of children, youth, and families. It means looking at individuals and their families holistically — seeing a child with both strengths and needs who is a part of a family and lives within a community. Families are big, small, extended, nuclear, multi-generational, with one parent, two parents and grandparents who may live under one roof or many. Families, whatever their makeup, are increasingly seen as groups of individuals with interrelated strengths and needs.[7]

Ultimately, collaboration must be systemic. Education, public health, social support, child care, housing, transportation, juvenile justice, employment training—these can all be elements of a comprehensive plan to make the service delivery system more responsive to the multiple and interrelated needs of the children and families it serves. A human service system that sees children and families together, a system that is committed to serving their needs and is shaped by those needs, would be more effective and compassionate than the current mix of separate, parallel, usually unconnected systems. Florida Governor Lawton Chiles calls what we have today "a system designed to frustrate."

Transforming our education, health, and social service systems into a more holistic enterprise is clearly the right idea. Achieving this broader goal will take time and effort, and it must begin with each of the systems involved. Collaboration between health care and education, however, is crucial. This must be the strongest pillar in system-wide reformation. This report is about building this pillar, but it offers lessons that are applicable to other human service collaborations.

[7] Report of the House Memorial 5 Task Force on Young Children and Families (1990). New Mexico, p.1.

Can We Mandate Collaboration?

Collaboration is a process, not a product. This makes it difficult to produce evidence of its existence and effectiveness for policymakers, particularly because those making policy usually do not come into daily contact with the children and families affected by it.

Though collaboration is at its core a local phenomenon, state and federal policymakers can create a policy environment in which local initiatives that integrate health and education services can flourish.

It is increasingly evident that "things trickle up," in the words of Rae Grad, executive director of the National Commission to Prevent Infant Mortality. Service providers and policymakers in local communities are on the front line. They see the problems facing children and families on a day-to-day basis and are aware of the resources within their communities. In PARTNERSHIP with the families they serve, they are in the best position to devise realistic and responsive solutions. State and federal governments can help with the successful implementation of those solutions. Policymakers at the national and state levels can take concrete steps to help local programs work. They can also provide incentives to—and eliminate barriers for— front-line service providers, giving them the opportunity to devote the considerable time and energy necessary to turn good collaborative ideas into reality.

Can We Legislate Leadership?

Ultimately, successful collaborative programs depend upon individuals who are committed, competent, and compassionate.

Policymakers have a responsibility to see to it that people with energy and ideas have the opportunity, the training, and the support to make those ideas work.

"You can have all the shoulds and oughts in the world, but you have to look at the people who will be implementing this grand vision," advises Atelia Melaville, senior research associate at the William T. Grant Foundation Commission on Work, Family and Citizenship. Policymakers should recognize that shared leadership is a crucial element in successful collaborations. They need to help leaders work collaboratively. "The idea of one major leader is arcane," says Sharon Lynn Kagan, associate director of the Bush Center in Child Development and Social Policy at Yale University. Support for collaboration must come from the top; if its leaders are trained to work collaboratively, they can provide support. The Collaborative Leadership Development Program, funded by the Danforth and Mott Foundations and implemented by the Institute for Educational Leadership, is an example of a program that attempts to develop the capacity of top officials to work together to develop, implement, and manage collaborative programs. It is a model for the support that can help joint leadership efforts succeed and produce results.

The Initial Spark

The first step in moving from agreement to action is to create a vision—and then a program to carry it out. Key players in these steps will respond to a push from higher levels of authority. Policymakers can facilitate this in two ways.

Bring attention to the problem

Public opinion is a powerful tool for obtaining better health care and education. With help from the news media, government can underscore the seriousness of the health care and education problems of children and families at risk and mobilize the public to support more effective programs. Douglas Besharov, Director for Social Policy Studies at the American Enterprise Institute, calls for an "Operation Domestic Storm." This, he says, would unite Americans in a fight against domestic foes with the intensity usually reserved for wartime. William Harris, the founder of the lobbying group KIDSPAC, suggests using the environmental movement's Earth Day campaign as a model for a public education and awareness campaign.

"Sadly, it often takes a crisis situation, such as a soaring infant mortality rate, to spur policy changes," according to the National Commission to Prevent Infant Mortality in its report, *One-Stop Shopping: The Road to Healthy Mothers and Children*. Local leaders can document community problems, assess needs, and share the results with service providers and the press. Reliable data, presented well, tell good stories to the public. Federal and state officials can create channels for disseminating similar information to states and localities. In addition to emphasizing the seriousness of the need, a public education campaign should provide answers. These would include the importance of collaboration, communicating the benefits of it to their community, and the partnership-building skills and training needed. The message also should be that all of these take time and patience.

"Sadly, it often takes a crisis situation, such as a soaring infant mortality rate, to spur policy changes."

National Commission to Prevent Infant Mortality

The basis for such a campaign already exists. The needs of children and families and the challenges to our health and education systems are well documented. Research in both fields consistently shows the benefits of early intervention and comprehensive services. For example, the multi-site Infant Health and Development Program found that comprehensive early interventions (including early childhood development, family support services, and pediatric care) for low birthweight, premature infants resulted in significantly higher mean IQ rates and fewer behavioral problems than the infants in a control group. We have the tools to lower the number of at-risk children who suffer damage from malnutrition, low birthweight, and neglect. Early intervention can make the difference. Policymakers must make sure information such as this is widely disseminated and used to garner public support.

Require collaboration in exchange for dollars and flexibility

Federal and state government agencies serving children and families can make collaboration at several levels a prerequisite for funding. Many successful health/education programs began as local responses to a request-for-proposals (RFP) from a state or federal agency. The planning process involved in applying for funds often lays the foundation for lasting collaborative relationships across agencies. Grant sponsors can require evidence of joint planning—signed contractual agreements between health care providers and education agencies, joint or reciprocal resource commitments, and multi-year plans reflecting real changes in service delivery—and hold recipients accountable to timelines for progress towards stated, measurable goals. Sponsors also can require that families be included in the planning, implementation, and evaluation process as a prerequisite for funding. This would ensure realistic and responsive programs.

Such goals should emphasize demonstrable improvements in program results. They should cut across the missions of participating agencies. Effective collaborations also should be rewarded with increased flexibility in administering programs and permission to move funds among agencies serving the same children and families.

Strategies to Facilitate Health/Education Collaboration

Successful collaborative efforts—and some that have failed—yield valuable lessons about the process and how to ensure that new initiatives will succeed. A review of hundreds of initiatives tells us of some common elements for federal, state, and local options.

Local Level: Planning and designing effective programs

- **Develop a common language, common goals, and a common definition of the problem and the population among health and education workers.** Too often, the same words mean different things to different people. Making these differences explicit and resolving them will help each participant understand his or her colleagues and foster better working relationships.
- **Instill ownership through a joint planning process.** Collaboration that begins at the planning stages of a project creates a sense of personal investment in a project that helps sustain the effort over time.
- **Appeal to the self-interest of participants.** Good incentives for collaboration include a reduction in other work-related responsibilities, increased authority to make decisions and allocate resources, and new sources of funding, according to Charles Bruner, executive director of the Child and Family Policy Center in Des Moines, Iowa. Along with financial and interpersonal rewards, the substance of the mission can be a powerful incentive to service providers frustrated by their own inability to solve intractable problems alone. For example, by cooperating with schools, health care providers can reach student populations more easily; by collaborating with primary health care providers and parents of preschool children, educators will see children who are better prepared for school.
- **Build in methods to resolve disputes.** Every collaborative effort will hit roadblocks, be they over funding, commitment, philosophy, or style. Anticipating disputes and designing ways to resolve them in advance can minimize their significance. One strategy is to include as much detail as possible in a contractual collaborative agreement at the outset, detailing how many hours and resources each participating agency will contribute.
- **Create programs that share responsibility and do not place excessive weight on any one overburdened system.** Avoid what Michael Usdan of the Institute for Educational Leadership calls programs that are merely "add-ons." Effective health/education collaboratives must become integrated into the mainstream activities of a school and/or a community. Ultimately, this means systemic reform for both systems.
- **Secure long-term resource commitments.** The original program design or proposal should incorporate specific estimates of each agency's contributions, including direct services, administrative and staff time, space, and materials. Although these estimates need to remain flexible, committing contractually to a multi-year program gives the initiative legitimacy and staying power.
- **Establish mutual accountability.** Agencies should agree upon a set of standards and a system to be used in evaluating the process and outcomes of their collaboration. The original agreement can include flexibility for mid-course corrections should the evaluation indicate the need.
- **Look for wheels before re-inventing them.** Almost every community has the beginnings of, or if fortunate, long-standing examples of collaboration among agencies. For example, federal mandates exist for collaboration regarding infants and young

children who are developmentally disabled and for programs under Even Start. Some of these initiatives may seem small, but any attempt at collaboration will yield lessons about success and failure.

State Level: Initiation, Advocacy, and Support

- **Set an example of collaboration.** Charles Bruner, notes that top administrative levels are "closest to state funding decisions but most removed from actual contact with clients." Despite the distance from families, high-ranking state officials can take important steps to demonstrate and facilitate collaboration; Bruner calls these efforts the "first generation approach" to collaboration. The creation of a single agency to oversee children's policy is one model for state-level administrative collaboration. However, there is a concern that lumping all programs for the poor together erases their broad-based taxpayer support and makes them extremely vulnerable to budget cuts. Interagency councils, agreements and/or joint statements of support and advocacy by education and health agency heads, backed up by concrete actions such as pooling funding streams and waiving bureaucratic barriers, can be powerful fuel to drive local initiatives.
- **Include funding for collaborative projects in state budgets.** It is unfair to ask collaborators to work with the fear that their funding may evaporate at any moment. Once a program has satisfactorily demonstrated its promise and worth, it should become a part of the budgets of the participating health agency and school system. Stable state funding not only provides a measure of financial security, but the credibility it lends also helps project planners leverage money from other sources.
- **Acknowledge that collaboration takes time.** States should be realistic and reasonable in providing necessary lead time. Individuals from different agencies need time to get to know each other and build trust if they are to feel comfortable working together. Programs that are hastily planned or rushed into implementation may not be strong enough to survive past the first glitch. Well-thought-out projects either anticipate problems or develop mechanisms to resolve them.

Federal Level: Demonstrating Models and Removing Barriers

- **Ease regulatory friction.** Agency heads can provide direction and force for collaboration among service providers by identifying and removing regulatory barriers that block the efforts of health and education professionals. Setting consistent priorities across programs, establishing common eligibility requirements, and decategorizing specialized programs where possible are good starts. The Medicaid Early and Periodic Screening, Diagnosis, and Treatment Program is one example: children served through the EPSDT are sometimes ineligible for Medicaid reimbursement for follow-up treatment. Recent federal initiatives have helped states ensure that follow-up treatment is covered by Medicaid regardless of eligibility.
- **Continue and expand collaboration among federal programs and agencies.** Recent examples of federal initiatives are encouraging. The current collaborations between the U.S. Departments of Education and Health and Human Services around the Individuals with Disabilites Education Act and the School Readiness goal signals an increased commitment at the federal level to integrate comprehensive services. In addition, Congress, in its 1989 budget act, directed the Secretary of Health and Human Services to develop a joint application form for seven federal programs serving pregnant women and children from birth to age six.

- **Increase the overall level of funding for programs addressing the health and education needs of communities at risk.** Collaboration should not become an excuse for reductions in already-strapped health and education budgets. It is clear that well-planned and well-designed collaborative initiatives may eventually save money by providing services more efficiently and by focusing on prevention rather than costlier remediation. However, investment in the infrastructure necessary to support and sustain programs is critical if the programs are to survive long enough to demonstrate their potential for savings.

SERVICE DELIVERY LEVEL: THE STARTING POINT FOR "TRICKLING UP"

- **Focus on prevention rather than remediation.** Children and families without primary, preventive care often must rely on emergency facilities, unnecessarily taxing those resources. Preventive care protects the health and learning abilities of our nation's children and is more effective and less expensive than care that comes too late.
- **Encourage family participation in program planning.** By providing families with opportunities to have meaningful roles, collaborations can build on family strengths and minimize attention to family "deficits." Families should be considered as advisors to any program which provides them services. When clients feel comfortable with the setting and set-up of a program, they participate more frequently and consistently.
- **Work out operational details in advance.** Health and education service providers should communicate before setting policies in order to avoid sending conflicting messages. For example, do not make a teenage girl choose between keeping a prenatal care appointment and risking disciplinary action at school because she misses class.
- **Create service inventories.** To avoid duplication, overlap, and repeat of past mistakes, compile up-to-date information on current health and education programs serving the target population, past and present reform efforts, and existing and potential funding sources.
- **Provide initial and ongoing professional development.** Staff development activities and cross-agency training can help staff understand each other's culture and responsibilities, provide current information on strategies to improve service delivery, and manage expectations about the level of commitment and length of time necessary to see results. There should be special support and initiatives for professional growth among those who evolve as natural leaders of collaborations.
- **Include service coordination.** A truly integrated program will inherently change the way children and families access the system. The point is to create ease of entry to obtain comprehensive services. This can happen all along the continuum of services, whether in health, education, or another agency. An initial needs assessment is important to determine which of the integrated services each family needs. These initial steps logically imply a case manager to follow through on the needs assessment and track a family's progress. Experience has shown that one of the biggest gaps in the system is the absence of a single person who is aware of the "big picture" for each family. An effective case manager is a person who has the time and access to know what services a family receives, the history of the family's interaction with different service providers, and whether families follow through with service recommendations and referrals.
- **Emphasize systemic reform.** There is a big difference between a program that provides service coordination simply to facilitate movement of a client through a system and one that provides service coordination in the context of a changed, family-friendly system.

- **Support families.** To best serve the child, the health and education systems must support families. The family—its strengths, priorities, resources and concerns—profoundly affects the health, development, and well-being of the child. By building on the strengths of families, which might include all of the significant adults in a child's life, collaborations can actively support families within their communities. The result will be a better life for their children.

- **Guard against attempts to replicate collaboration for collaboration's sake.** Bruner warns of "model drift," the weakening of collaborative initiatives that occurs when policymakers attempt to replicate successful efforts by simply exporting a package and imposing it on a new set of providers and organizational structures. A more successful approach develops a vision of what can be accomplished through collaboration, then provides initiatives and support to local leadership and ideas committed to and capable of carrying out the vision. Everyone can learn from successful models; every initiative needs to be unique.

Moving Past the Barriers

An important theme emerges from a review of collaborative programs. Though the barriers to collaboration are real, the need is so great and the problems so severe that traditional obstacles have become less pressing than they once were. The increasing number of drug-exposed infants and children is a vivid example. Abandoned "boarder babies" and sick infants born prematurely with special needs have mobilized the health care and early childhood communities into action. Together, educators and health care providers are seeking information about these children and developing programs to help them.

Health providers and educators from states and communities around the country express enthusiasm and excitement about the prospect of collaboration. They are no longer stymied by the logistical barriers that once separated them. As this willingness to work together continues to grow, the opportunities for collaboration can eclipse the obstacles in the way.

Why Those Empty Seats?

The plight of children with asthma presents an example of barriers not yet overcome. According to the American Academy of Allergy and Immunology, asthma is the leading cause of school absences. Recent developments have made it possible for children anticipating an asthma attack to prevent it by using peak-flow meters as soon as they detect symptoms. However, barriers block their widespread use. Legal restrictions prohibit medicine in the classroom. Fear of liability prevents teachers and principals from allowing children to administer the medication themselves. Communication between health professionals and educators could help break down these kinds of barriers by informing teachers, coaches, and principals about the use and benefits of such interventions.

Barriers do still exist, of course, and often include:

- Providers who guard their turf and are threatened by sharing information and resources with outsiders.

- Confidentiality requirements which legitimately protect the flow of information on individual clients but may also prevent an open exchange of information about individual children and families.

- Rigid and narrow eligibility requirements that make it difficult to design collaborative programs serving a broad population of children and families with multiple needs.

- Disparate organizational structures and operating procedures that get in the way, as staff from various agencies try to find common meeting times, create joint governance structures, and develop mission statements that include all participants.
- Federal, state and local program requirements that are at cross purposes.

Finding the Funds

In a context of fiscal restraint, funding issues loom large. New money is hard to obtain, and reallocating existing resources is fraught with political tensions. Successful collaborators must be realistic in recognizing these tensions and addressing them up front. Several key issues arise in connection with funding.

Scarcity

Collaboration between health and education agencies in and of itself cannot solve the problems of scarce resources, particularly in the short term. "The best use of money does not overcome the absence of money," points out Julia Lear, co-director of the School-Based Adolescent Health Program. Collaboration does not absolve policymakers of the responsibility to devote more absolute resources to fulfilling the health and education needs of children.

However, the current fiscal crisis need not be a brick wall. A fiscal crunch can be an opportunity for providers to look closely at their programs, decide what strategies are the most effective, "get rid of the dinosaurs," and develop innovative ideas to pool limited resources, comments Dr. Howie Spivak, director of ambulatory pediatrics at Tufts University School of Medicine. Packaged and promoted effectively, collaborative solutions that show promise of eventual savings and increased efficiency can provide a politically attractive alternative to business as usual. In addition, even when money is available to fund health and education services, that alone does not solve many of the problems of the current system. We have to improve the system as well as fund it adequately.

Funding Streams as Incentives

The importance of incentives cannot be overemphasized in overcoming resistance to decategorization of funding. Public interest groups fear the reduction of resources for their particular agendas which, to some extent, will likely be decategorized. Other providers and local policymakers can be protective of their "slice" for similar reasons.

State and federal programs can provide incentives for collaboration by giving providers and local policymakers more flexibility in using existing resources and by building that flexibility into new programs. Pooled or decategorized funding allows local officials to use allotted funds most effectively, including shifting them among programs when necessary and serving children and families whose problems have not yet become severe enough to qualify them for restricted programs.

While blending restricted state and federal funding streams is an important goal, program planners must also learn to work within those restrictions over the short term in order to best use those resources. Providers using various categorized programs—including Aid to Families with Dependent Children, Chapter 1 for educationally disadvan-

taged students, and Medicaid—traditionally have not communicated with one another, leaving children and families without a coherent service plan and with no one keeping track of their progress across these programs.

Even if funding remains categorical, collaboration among service providers working within each program will reduce duplication, increase the understanding of each provider of the factors affecting client progress, and serve the health and education needs of children and families more coherently. Such initiatives will require planning to assure accountability through specific process and outcome measures.

Importance of start-up funds

It is understandable that state legislatures are unwilling to fund prospective projects without substantial promise of success. However, given the need for thorough planning and careful implementation, states should provide funding, or at least assist local planners in obtaining outside funding, for planning and start-up costs. After a state-sponsored evaluation of these initial efforts, states should commit to providing stable, continued funding for programs they deem promising and truly collaborative.

Defining the Target Population: Young Children, Adolescents, and Families

Successful health/education collaborations take different forms for many reasons—the nature of the community, the magnitude of the problem, the location of services, the availability of resources. In particular, programs aimed at very young children differ from those targeting school-aged children and youth. In developing an effective intervention, says Margot Kaplan-Sanoff, an associate clinical professor of pediatrics at the Boston University School of Medicine, "you have to go where the kids are." High school-age youth are in school. Younger children and pregnant mothers can be in various locations, very often medical settings. Planners face different considerations in designing collaborative efforts for children of differing ages.

Prevention at its earliest stage: children from birth to five years and their mothers

Reaching pregnant women and very young children and their fathers is a way to build a preventive focus into a collaboration between health care providers and educators. Both have a major stake in the healthy and normal development of young children. According to Rae Grad, "We are putting too much money on the wrong end of the equation when it comes to preventive versus remedial services." Studies have shown the benefits of investing in prenatal and early childhood care rather than waiting until problems manifest themselves later on. Benjamin Bloom, a professor at the University of Chicago, noted 25 years ago that the amount of intellectual development taking place from conception to age four equals the development that occurs from age four to age 18. Comprehensive prenatal and infant care can remove the barriers to a healthy beginning for every child and make the most from the promises of a new life.

The House Select Committee on Children, Youth, and Families has found that: $1 spent on Women, Infants, and Children (WIC) supplemental feeding programs saves $3 in

short-term health care; $1 spent on early childhood education and development saves $4.75 in future social costs; $1 spent on prenatal care saves $3.38 in treatment for low birthweight infants; and $1 spent on providing prenatal care to pregnant Medicaid recipients saves $2 in medical care during an infant's first year of life. For every $1 spent on immunizations there is a savings of $14.40.

One of the greatest threats to school readiness and the general well-being of children is lead poisoning, which can have serious consequences for physical and intellectual development. Children suffering from lead poisoning are far more likely to drop out of school and develop academic disabilities than other children. Unfortunately, fewer than one in 10 children is screened for lead toxicity. It is usually identified only after serious damage has occurred. However, the Health and Human Services Strategic Plan for the Elimination of Childhood Lead Poisoning, issued in February 1991, showed that the benefits of investing in a comprehensive program to prevent lead exposure outweigh the costs by nearly two to one, a powerful argument for committing resources to prevention.

Early care is crucial if we are to achieve the first National Education Goal of school readiness for all children by the year 2000. Sharon Lynn Kagan of Yale University contends that if we are to meet the readiness goal, collaboration is vital. Lucille Newman, professor of community health and anthropology at Brown University, and Stephen Buka, epidemiologist and instructor at Harvard Medical School and School of Public Health, agree: readiness depends on many factors related to the physical and psychological development of children. Topping their list of preventable factors impairing school readiness are low birthweight and destructive behavior during pregnancy. The Infant Health and Development Program, a large-scale study of the positive effect of early intervention on at-risk infants, concluded that a combination of health care and education was more effective in enhancing the development of low birthweight babies than health care alone.

PREVENTION AND REMEDIATION FOR SCHOOL-AGE CHILDREN

For children already in school, school-based programs are one of the most effective methods of reaching and enrolling them for services. "I've never met a young person who carried an appointment book," says Dr. Philip Porter, an associate professor in the Department of Pediatrics at Harvard University. He stresses that effective health services for adolescents must be located in schools. "If they have to go some place after school, 99 percent won't go, and the impact will be lost." Advantages of locating health/education programs in schools include:

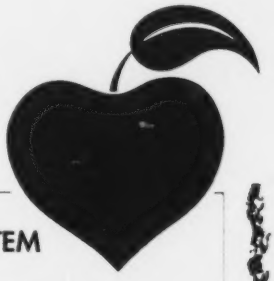
- care is easily accessible and immediately available;
- students will miss less school traveling to health facilities;
- school-based staff are trained to help adolescents;
- schools have well-developed record-keeping and tracking systems which could include health records;
- health care staff become a trusted part of the school community; and
- all children have an opportunity to become part of the health system early and form good habits about their physical care.

Health care programs located in schools can often reach children and youth before their problems become serious enough to force them to seek emergency care. Also, school-based clinics can work hand-in-hand with schools to establish a comprehensive

health education program, which can effectively improve health and encourage healthy behavior. "If there is a resource there where they can go when the light goes on, they can get involved with services before problems occur," explains Dr. Porter.

Though school-based programs are to some degree remedial and reactive, they are also consistent with the focus on preventive services. Children of teen mothers are more likely to suffer from low birthweight and inadequate medical care; reducing teen pregnancy rates would help eliminate these problems. Newman and Buka point to "preconceptional" care as an effective way to prevent health problems, reaching teenagers before they become pregnant with counseling, tutoring, training, and other services that may prevent pregnancy. Some school-based clinics have been very successful in providing such preconceptional care to teenagers. Prenatal care, another of Newman and Buka's recommended preventive strategies, is also bolstered by school-based clinics, which have contact with and access to pregnant teens. The staff of school-based clinics, however, spend most of their time on more mundane ways of preventing serious problems, treating colds, acne, diets, and emotional needs before they become major health risks.

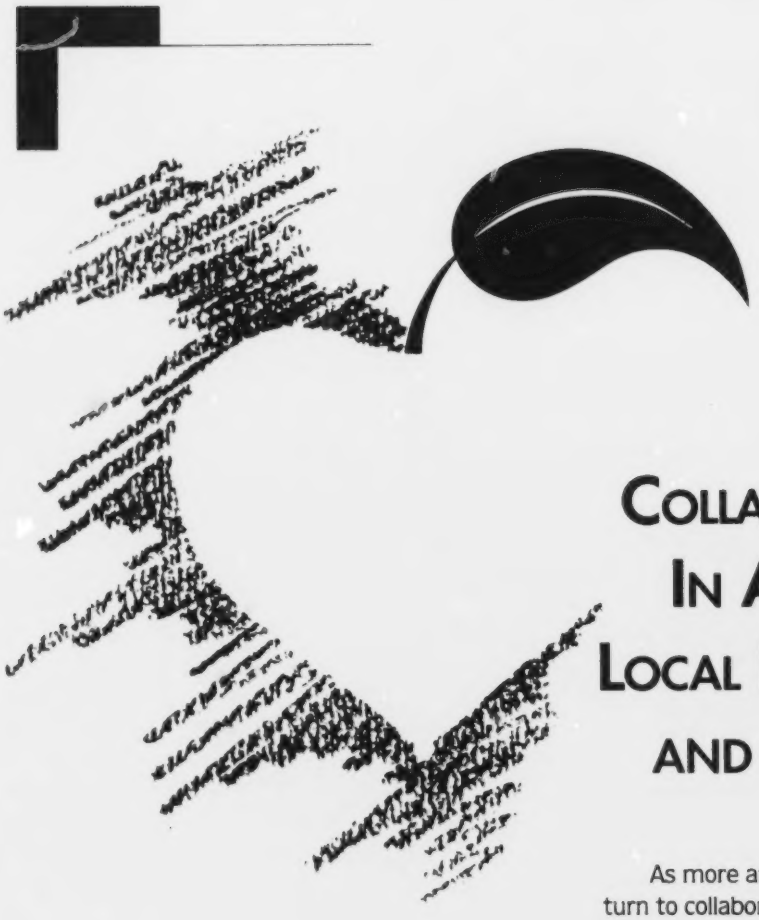
Asthma sufferers are another group benefitting from school-based services. The resources necessary to pay for two annual emergency-room visits for six students suffering from asthma would cover the cost of over 3,000 individual visits to a school-based health center for one year. In addition, according to the American Academy of Allergy and Immunology, $1 spent on education for children with asthma can lead to a savings of $11.22 in health care costs. For their part, states can work with schools to obtain certification as Medicaid providers to help defray the local cost of clinics and utilize available federal resources more effectively.



Conclusion: Changing the System

A system focused on children and families necessarily involves interagency collaboration. Without collaboration, there really is no system at all. Children and families have multiple and interrelated problems, and a system dedicated to serving their needs must in turn be interrelated. Money must follow children, not programs. And programs should be accountable by how well they serve the needs of children and families, not only by their ease of operation.

Collaboration is not an end in itself but a means to an end. It is a process, not a product. Successful collaborations facilitated by wise and well-informed policies, as described in the next section, can serve as a springboard to lasting systemic change.



Collaboration In Action: Local Programs and Policies

As more and more communities turn to collaboration, programs integrating health and education are increasing in number. Their positive effects are beginning to "trickle up." These collaborative efforts take many different forms, involve many different agencies and individuals, and serve a variety of populations.

The programs highlighted in the following section are examples of current efforts to serve children and their families more effectively by bringing together health and education services. The programs are in different stages of implementation, and all have their strong and weak points. We believe they are instructive for individuals contemplating, or in the process of building, health and education collaborations. Contact information is provided.

Action at the Local Level

Program	Location	Target Group	Purpose	Funding
Operation Family	Lexington, Kentucky	Low-income families	Establish a sustained collaboration among local service providers	Federal grant + local budgets
Child Development Project	Boston, Massachusetts	Preschoolers	Supplement medical care with appropriate early childhood education	Local budgets
Children's Health Project	Great Barrington, Massachusetts	Infants, children and families	Coordinate public health and education services in rural community	Federal grants + federal programs + private funds
Steps Towards Effective Enjoyable Parenting	Minneapolis, Minnesota	At-risk pregnant woman and infants	Provide pregnant women and new mothers with child education and health information	Local budgets
Parents as Teachers	St. Clair County, Missouri	Families with preschoolers	Identify and treat health and developmental problems	Local budgets + federal programs
Salvin Special Education Center and 75th Street School	Los Angeles, California	Drug-affected children	Provide comprehensive educational and health services for drug-affected children	State funds
Birth to Three	Los Angeles, California	Pregnant drug users	Help women deliver drug-free babies	Federal grant
Cooperative Pediatric Project	Miami, Florida	Drug-affected infants	Increase coordination between providers serving the same infants	State funds + local budgets
Therapeutic Preschool Program	New York, New York	Drug-affected preschoolers	Develop and share strategies to prepare children for school	Local budgets
Preschool Coordinating Council, Inc.	San Francisco, California	Drug-affected infants and children	Identify health and education needs and provide services	State funds + private funds
Ensley High School Health Center	Birmingham, Alabama	Adolescents	Provide comprehensive on-site medical care and health education	Foundation grant
St. Paul/Ramsey Medical Center	St. Paul, Minnesota	Adolescents and their children	Combine adolescent health services with child care	Local budgets
Young People's Health Connection	Baltimore, Maryland	Adolescents	Provide easily accessible health information and services in a shopping mall	Local budgets
Lafayette Courts Family Development Center	Baltimore, Maryland	Low-income families	Coordinate all health and social services for residents of a public housing complex	Local budgets + federal grant
New Beginnings	San Diego, California	Children and families	Provide comprehensive services for families	Local budgets + foundation grant
Center for Successful Child Development	Chicago, Illinois	Children and families	Combat the effects of an urban environment by providing integrated services to young children	Local budgets + federal programs
Communities in Schools	Wake County, North Carolina	Adolescents, children and families	Provide health and social services at school site	Local budgets + private grant
Communities in Schools: Burger King Academy	San Antonio, Texas	Adolescents	Provide health and social services at school site	Local budgets + private grant + federal program

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The Process of Collaboration

Operation Family

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Community Action Council
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Lexington, KY 40576

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Before local programs can bring about systemic change in the delivery of services, the service providers must become accustomed to the idea and the process of collaboration. **Operation Family** in Lexington, Kentucky, reflects one community's efforts to change its procedures in order to enhance cooperation between health and social service providers and educators. A grant from the U.S. Department of Health and Human Services brought together service providers to develop a collaborative program for low-income families. The major legacy of that planning process has been a sustained collaborative relationship between agency heads, who meet monthly as an Interagency Policy Board. Service providers in any line agency who experience barriers to collaborative efforts bring the issue to an interagency review committee; in turn, it can present intractable conflicts to the Policy Board. The board members, who include the superintendent of schools and the commissioners of health, education, and social services, along with representatives from Head Start, vocational training, and child care, review and adjust policies to facilitate collaboration. To date, it has been unnecessary to take any conflicts which have arisen to the board; issues have been resolved within the interagency review committee. For example, Operation Family contracts with seven community child care providers as a part of the services required in the grant. The interagency review committee set up and streamlined criteria for contracting with these different providers without having to go through the board. A full-time staff person funded through the grant identifies gaps in the system and refers them to the review committee.

Preschool Programs

Child Development Project Boston City Hospital

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Professor of Pediatrics,
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Boston City Hospital
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Located in a large, inner-city public hospital serving a low-income, predominantly minority population (African-American), the **Child Development Project** picks up where the traditional health services provided in a public hospital setting leave off. Pediatricians concerned about children with health problems that endangered their healthy development created a program in conjunction with early childhood specialists. It brings an educational and developmental component into medical settings. Though the project began as an assessment and referral mechanism, the participants quickly realized the gaps in service delivery and set about to fill them, moving to an intervention and prevention focus. Educators work with children at the hospital; they also provide training and information for pediatricians and medical students on early childhood education.

The success of this collaborative effort inspired the staff of the child project to develop other programs designed to combine health care and education for preschool-aged children. Through **Reach Out And Read (ROAR)**, funded by outside grants, pediatricians give children developmentally appropriate, multi-cultural books at every well-baby check-up from the time the children are six months old. The doctors also spend time with parents explaining the value of language skills, particularly reading, for young children. Volunteer readers staff waiting rooms, reading aloud to children and demonstrating techniques to parents. Early childhood specialists work with the pediatricians to find appropriate books. In **Project Visit**, funded by a grant from the Office of Special Education and Rehabilitative Services in the U.S. Department of Education, medical professionals identify children placed in full-time child care who should be receiving medical services. The staff visit child care programs, identify children with developmental delays, and work with them on-site.

Children's Health Project
Great Barrington, Massachusetts

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Executive Director
Children's Health Program
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After determining the lack of health care services for young children in 1975 in the rural towns south of Berkshire County in Massachusetts, a health planner brought together area dentists; the visiting nurse director; and the area's newest physician, pediatrician Thomas J. Whitfield. Dr. Whitfield proposed traveling well-child clinics to be taken to rural schools, churches, and town halls. An early childhood educator, Linda Small, found many of the area's children were reaching kindergarten with health and developmental problems that prevented them from achieving well in school. She proposed educational services for parents as part of the clinic services. The result was the **Children's Health Project (CHP)**, which today shelters and supports five health and educational programs for parents and children.

According to Small, parents would like to do as much as they can to prepare their children for school, but many do not know how. Furthermore, many rural parents do not have time to "chase services." Thus, the team sought to provide a global resource under one roof. Today, board-certified pediatric nurse practitioners conduct well-child visits, provide health education, treat acute care problems, and act as case managers for 400 children, birth to 18 years.

CHP offers new parents WIC nutrition services; a Parent-to-Parent trained home visitor to be a "buddy" during the infant's first year of life; and weekly play groups for parents and children to share a social/educational get-together that promotes socialization, language development, and cognitive skills. Young adolescent mothers are offered a wide variety of services to build the competencies they will need; driver's education and licensing exam support is the first step, followed by tutoring and support for passing the GED exam. One-on-one support from retired teachers and other women is now being extended to provide "mentorships" with professional women in the communities.

Funding for CHP comes from many sources: the Massachusetts Department of Public Health, Berkshire United Way, Medicaid patient fees, third party payers, local churches, foundations, and a vibrant fund-raising effort by the CHP board of directors. All programs, excluding WIC, are available to all families regardless of income.

Steps Towards Effective Enjoyable Parenting (STEEP)

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STEEP
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Because they are not yet enrolled in school, one issue in serving young children is how to reach them. The **Steps Towards Effective Enjoyable Parenting (STEEP)** program in Minneapolis, Minnesota, fills an important gap between health care and early childhood education by locating at-risk women and infants through obstetric/gynecological clinics. Program staff work with clinic staff to locate and recruit low-income, first-time mothers. Serving as case managers, they work with pregnant women, mothers, and children from birth to age two at the clinics, in their homes, and in group meetings on parenting, developmental issues, health care, and other needs. A primary goal of the program is to explore how the parents' own early care influences their relationship with their child.

Parents as Teachers

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The **Parents as Teachers (PAT)** project in St. Clair County, Missouri, is part of a statewide program aimed at increasing parent involvement in education. PAT is a relatively new concept that was first initiated in Missouri and is being implemented or considered in a number of other sites. The collaboration between some local school districts and the St. Clair County Health Center was born when a school superintendent approached the health department five years ago for assistance in providing parent services. The St. Clair County Health Department developed a program through which three parent educators work with six small, rural districts, spreading the burden of salaries and overhead across the districts. The educators remain under the jurisdiction of the health department and work closely with school personnel.

Women come to the health center for child care, prenatal care, the federal WIC program, and other public health benefits. Pregnant women and mothers are automatically referred to the Parents as Teachers program, which coordinates its services with these other programs to provide a comprehensive plan for families. County birth lists also identify potential participants. Parents sign up for the program through the schools, which then notify the health department to begin services. The parent educators visit homes of children aged 0-4 to work with parents on health-related issues and screen children for possible problems that could impinge on school readiness. They report monthly to the schools on the care of individual children and families. By working with young children, the parent educators have picked up many problems before children reach school age. They then work cooperatively with parents, health providers, and schools to resolve the problems.

Preschool Coordinating Council, Inc.

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Executive Director
Preschool Coordinating
Council
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Pittsburg, CA 94565

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The **Preschool Coordinating Council, Inc. (PSCC)**, is a community-based, non-profit, tax-exempt agency whose mission is to assist low-income families in becoming self-sufficient through education and training. Its newly erected facility is adjacent to the Contra Costa County El Pueblo Housing Project in Pittsburg, California. It provides licensed year-round developmental day care to an infant/toddler program for drug-affected infants, as well as a comprehensive before- and after-school program for children up to 11 years of age.

In addition to a developmental and academic curriculum based on identified needs and emphasizing a positive self-image, PSCC offers programs and materials aimed at substance abuse prevention, child abuse prevention, and career choice information and experiences. Referral services are provided for all families.

A team of teachers, a case manager, a nurse practitioner, and a family therapist use information from public school teachers to assess the needs of children with academic, health, or behavioral problems. Staff work closely with parents to suggest home-based strategies. The nurse practitioner maintains a close relationship with nearby Children's Hospital and can speed treatment for children in the program. She also spends time training the teaching staff in health-related areas.

Funding comes from the state Department of Education Office of Child Development, Contra Costa County, City of Pittsburg, and private foundations.

Salvin Special Education Center

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Administrator
Salvin Special
Education Center
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Los Angeles, CA 90007

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One of the most critical challenges facing the health care and education systems is the effect of prenatal drug exposure on the health and development of infants and children. The Los Angeles Unified School District Division of Special Education has brought together a team of early childhood educators and medical and social service professionals to address the unique problems of this population. Funded by the state Department of Special Education, this pilot program at **Salvin Special Education Center** serves children aged three to five in a preschool setting and children from five to seven in a kindergarten program, located at the 75th Street School. Teachers and their aides work closely with a pediatrician, psychiatric social worker, school psychologist, and parents to provide a program that encourages the healthy development of the children enrolled in the school.

Because it is based in a public school, the program incorporates traditional school services, including physical education, speech and language therapy, and school nursing. Pediatricians consult with staff and parents; teachers and social workers conduct home visits to supplement the educational program. The program has been most successful when collaborators have enough time to meet regularly and repeatedly, according to Carol Cole, a teacher at the Salvin Center.

Other Los Angeles Initiatives

The epidemic of crack cocaine began about five years ago, and schools are beginning to feel the impact of the unique characteristics and needs of children born to women who used drugs during pregnancy. The challenge will become greater as the numbers of drug-affected children continue to grow. Carol Cole, comments: "If there is anything hopeful about prenatal drug exposure, it is that it forces us to collaborate. Health care providers and early childhood specialists in many communities have responded to the challenge with joint efforts designed to serve drug-affected infants, children and their families and help prepare them for school.

Los Angeles has been among the most active communities in recognizing and addressing this need. The programs at the Salvin Special Education Center are one example. Another is the **Birth to Three** project administered by the University of California at Los Angeles in collaboration with a medical center, with funding from the U.S. Department of Education. Pregnant drug users receive prenatal care and counseling to help them deliver drug-free babies. Case managers from the medical and social service communities guide mothers to appropriate treatment and counseling.

In a similar program, based at a hospital in a high drug-use area, child development specialists provide neighborhood-based education for mothers and intervention services in the homes of drug-exposed infants. The state child protection agency works with the hospital staff when children reach 18 months of age to provide case management for families and early childhood education services. The Los Angeles Unified School District has developed pilot programs to continue working with the children from these early-intervention programs and prepare them to enter school.

An interagency, citywide **Council on Perinatal Substance Abuse of Los Angeles County** brings together service providers and policymakers from the health, education, and social service sectors to share information and strategies. The state contributes support through the Department of Alcohol and Drug Programs. It has encouraged communities to develop collaborative strategies around the issue of prenatal drug exposure.

Cooperative Pediatric Project

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Cooperative Pediatric Project
Department of Health and Rehabilitative Services
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Suite N1007
Miami, FL 33128

(305) 377-5055

Other cities also have begun to address the needs of drug-affected infants. In Miami, Florida, a collaboration between the state Department of Health and Rehabilitative Services and the University of Miami/Jackson Memorial Medical Center, the **Cooperative Pediatric Project**, has been established to address timely placement needs of identified substance-exposed newborns. Weekly staff meetings with relevant personnel from the hospital, HRS, and community agencies work toward maintaining the best possible intra- and inter-agency communication so this special population of high-risk infants and their families can receive assistance in a timely and thorough fashion.

Harlem Hospital Therapeutic Nursery

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Therapeutic Nursery
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Faced with a growing number of drug-affected infants and children in Harlem, the New York City Mayor's Office of Drug Abuse Policy awarded a grant to a citywide school district's special education division to develop a preschool program designed to provide special services to these children. The school district's early childhood coordinator contacted the developmental pediatrician at Harlem Hospital and then invited a community school district to participate in the project. The hospital and school districts contribute staff time and space to the project.

The three-way collaboration among medical professionals, general educators, and special educators resulted in a preschool program based at the hospital where drug-exposed toddlers and preschoolers attend a therapeutic nursery. The special education teachers infuse educational strategies within the therapeutic environment, while the pediatrician, medical interns, and nurses contribute developmental and medical expertise and services. Kindergarten teachers and pre-K teachers from the local school district rotate into the program and observe classes and teaching strategies in preparation for the influx of similarly affected children into their classrooms. Educators and health providers meet weekly to discuss individual children, and they jointly sponsor workshops for parents on child development issues and home-based education.

The **Harlem Hospital Therapeutic Nursery** program is an outgrowth of a broader collaborative effort underway in New York State. A researcher from the state Department of Substance Abuse Services has brought together medical researchers and representatives from the state education and health departments to share information and ideas on the effects of in-utero drug use on cognitive, social/emotional and physical development. Planning teams from this research collaboration write proposals for federal grants that involve interagency collaboration around this issue. Nancy Needle of the citywide Board of Education envisions other "marriages" like the preschool project resulting from this multidisciplinary research team.

School-Based Health Centers

Because of widespread agreement that locating health services in schools is an effective way to reach adolescents, school-based health centers are gaining in popularity across the country. Several national organizations provide support and technical assistance to local providers on the start-up and operation of school-based centers. These include the Center for Population Options, which operates the Support Center for School-Based Clinics, and the Annie E. Casey Foundation's New Futures initiative, which provides multi-year grants to four cities for comprehensive services to at-risk youth. Two of the four current sites have school-based health centers. Foundation funds have been used to upgrade facilities and train personnel in order to qualify the centers for EPSDT certification. Once certified, the centers receive reimbursement from Medicaid and can serve more children. Another major player on the national scene is the Robert Wood Johnson Foundation. In conjunction with Harvard University and the Children's National Medical Center, the foundation administers the School-Based Adolescent Health Care Program.

School-Based Adolescent Health Care Program

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➤ Julia Lear
Co-Director
School-Based Adolescent
Health Care Program
Children's National
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Washington, DC 20010

(202) 745-2000

This program awarded 19 grants of up to $600,000 each over a six-year period, beginning in 1987, to medical providers working with schools and community agencies to establish comprehensive health centers. Each site funded through the program had to demonstrate collaboration by submitting signed letters of support from the school principal, school board president, city health officer, parent organization, and mayor in order to receive a grant. Other requirements included multi-year financing and service plans and evidence of an active community advisory board and of potential funding sources after the grant expired. Several sites failed to receive grants when they could not obtain the requested letters. Perhaps because of the success of these prerequisites in weeding out weak collaborations, the funded centers are demonstrating success.

Midway through the grant period, each grantee produced a comprehensive progress report detailing the nature of health problems among the student population and describing the services and successes of the centers. The reports also serve as marketing tools to attract public and private funders to support the centers when the grants run out. The two programs cited below are a part of the School-Based Adolescent Health Care Program.

Ensley High School Health Center

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The **Ensley High School Health Center** in Birmingham, Alabama, developed from a collaboration between the Jefferson County Board of Health and the Birmingham Board of Education, acting in response to the Robert Wood Johnson Foundation's call for applications. Among the services provided to Ensley students are acute and chronic health care, physical examinations, screenings, reproductive health care, nutritional and diet guidance, and substance abuse counseling. Faculty referrals are commonplace, as are voluntary student visits. Health center staff stress health education and preventive care.

The staff established a peer education student club which has carried out some very effective educational projects. One such project was a violence prevention week featuring school assemblies, rap/poster contests, as well as classroom education about violence prevention. The students in the health club also wrote and produced a play called *Silent Cries*, which addresses many adolescent issues such as suicide, drug abuse, and family violence. The play has been performed for the entire student body, several middle schools, and community leaders.

Baltimore City Department of Health

Contact:
➤ Bernice Rosenthal, Health
Program Administrator

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➤ Pat Papa, Nurse
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Medical Director

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Experiences in this and other communities have yielded lessons about the implementation of school-based clinics. Nine Baltimore high schools have full-service school-based clinics providing medical care, health education, and teen pregnancy prevention programs to over 6,000 students each year with funding from the **Baltimore City Department of Health** and private foundations.

The principal goals of the Baltimore City school clinics are to improve adolescent access to health care and to improve adolescent health status. Primary and secondary prevention of teenage pregnancy is an integral part of clinic activities. Evaluation efforts are underway to measure the effectiveness of the clinics in preventing births to adolescent mothers and improving birthweight outcomes.

The program experienced initial difficulty in integrating traditional school nurses, who tended to emphasize counseling and education, with the more medical focus of the school clinic. Initially, the school nurse and personnel from the school clinic reported to different supervisors. Looking for a way to integrate the programs, health department supervisors for the school clinic and the school nursing program met to redefine the roles of the nurses and the nurse practitioners in serving the health needs of the students. As a result, the health department changed its governance structure to allow the school nurse to take over the role of clinic coordinator. The nurse practitioners, relieved of administrative duties, were able to concentrate on patient care. The integration and collaboration between traditional school nurses and the clinic's nurse practitioners resulted in a more efficient division of labor and more effective method of service delivery.

Health Start

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Health Start
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St. Paul, MN 55101

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Two important strategies for designing successful programs for adolescents are to avoid situations where youth will feel stigmatized and to locate centers where teenagers will use them. **Health Start**, a non-profit organization in St. Paul, Minnesota, resolved both these issues in designing a collaborative effort with an inner-city high school in 1973. The St. Paul/Ramsey Medical Center in St. Paul supported a teen pregnancy clinic. However, it was not well utilized because adolescents did not often travel to the center. The high school contacted the hospital for help in finding day care for its students' children. This contact led to a collaboration that created an adolescent health center/child care facility in the school. **Health Start** (formerly a part of the medical center) now manages five school-based health centers in St. Paul.

Services are more comprehensive than they were in the original clinic and include general adolescent health care, prenatal care, sports physical examinations, counseling, nutrition assessment, and health education. Services focus on adolescent health promotion. By increasing the variety of services, the clinics serve more students and do not have the stigma of a reproductive health clinic.

Young People's Health Connection

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➤ Dena Green
Project Director
Young People's Health Connection
109 Mondawmin Mall
Baltimore, MD 21215

(410) 396-0353

One program has devised an alternative way to reach adolescents at risk: the **Young People's Health Connection** is located in a shopping mall in Baltimore, Maryland. Funded and staffed through the Baltimore City Department of Health, the program provides health services, family planning counseling, AIDS information, sports physicals, screenings, and recreational activities for children and youth aged 10-24. Nurse practitioners from the center visit local public schools to provide on-site counseling and informational sessions; they provide some direct services at the schools and refer students to the center for additional treatment when necessary.

Cities in Schools

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National Cities in Schools Office
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Dedicated to dropout prevention, **Cities in Schools** (CIS) develops community-based public/private partnerships designed to connect appropriate human services with at-risk youth. The program addresses such issues as attendance, literacy, job preparedness, health, teen pregnancy, drug and alcohol abuse, teen suicide, and school violence. CIS operates as a broker between the schools and service providers by repositioning providers into schools where they work directly with students alongside teachers, volunteers, and mentors. Of the 61 CIS local programs, 31 have located health and substance abuse prevention services on-site in schools. Due to the geographic area of certain CIS sites, some projects have named themselves Communities in Schools, such as the two programs described below—in San Antonio, Texas, and Wake County, North Carolina.

Wake County, North Carolina Communities in Schools

In Wake County, North Carolina, Communities in Schools takes on different shapes in the six schools CIS serves. Students are referred by principals, teachers, and agencies which work with them and/or their families based on at-risk factors and with parental permission. The County Director of Public Health has located school health nurses and increased nurse time to one full day per week at all CIS sites. These nurses serve all students at the school; however, special priority is given to the needs of those enrolled in the CIS program. Initial health screenings of CIS students by these nurses help to determine which providers CIS will bring into the school. An interagency team meets bi-weekly on site to discuss specific needs of CIS students and their families.

Each site has an "Agency Day" when students have access to personnel from different agencies. For example, at **Zebulon Middle School**, students and their families can meet with the Department of Public Health; Department of Social Services; Department of Family and Children Services (mental health); a team member from the Duke Hospital Substance Abuse Program; and Haven House, a private non-profit family service agency. Screenings by public health workers have detected such problems as vision impairment, diabetes, and the need for changes in medication for such chronic illnesses as asthma. All of these can severely impair student achievement as well as attendance. For problems not treatable on site, students are referred to a free county clinic, and transportation is arranged. Funding for health personnel is covered under the county health department budget, although the health department's school health program manager is seeking outside funding to increase the number of nurses at the CIS sites.

Interagency policy conflicts have been minimal. For example, confidentiality is addressed by a broad release statement signed by parents at the beginning of the year that allows the interagency team to share information in order to serve the students and their families. The staff also makes an effort to keep in close communication with families regarding any referrals to specific services.

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San Antonio Burger King Academy Communities in Schools

In San Antonio, Texas, Cities in Schools has been renamed Communities in Schools. However, the program still operates as a CIS site. In partnership with the U.S. Department of Justice, the Burger King Corporation and the Harlandale Independent School District, CIS operates 10 "**Burger King Academies**" which are alternative schools for students who do not flourish in a traditional academic setting. The San Antonio Burger King Academy serves a 100 percent Hispanic student body at grades 9-11. Recognizing that the majority of the students had no dental care and that such care is important to self-esteem and dental hygiene, CIS brokered an agreement with the University of Texas Health Science Center. It provides on-site dental care for students through a traveling dental lab. Work at the school is considered as a rotation for dentists in training who must meet a certain number of community service hours; the university pays for the dental services out of student lab fees. Staff indicate that besides providing valuable health services to the school, having the dental lab visit the school has increased students' interest in health careers and dental health in particular.

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Other health-related services provided on site by outside agencies include birthing classes for pregnant mothers and their spouses or partners, as well as a substance abuse program. Both of these services include small groups as well as the classroom format. A local association of professional optometrists also provides free eyeglass exams at the school. These services are brokered by the project director/counselor.

One-Stop Shopping

One type of collaboration is known as the "one-stop shopping" model. In its recent report on this type of program, the National Commission to Prevent Infant Mortality writes that "one-stop shopping strategies should help locate, enroll, support, motivate, educate, advocate, and provide services for pregnant women, new mothers, and their families." Programs of this type cast their nets wide and include as many service providers as possible in an effort to fill the gaps. Their single point of entry can be accessed anywhere in the system.

Lafayette Courts Family Development Center

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Lafayette Courts, a large public housing project with 2,500 residents in inner-city Baltimore, is home to an example of the "one-stop shopping" model of collaboration. The **Lafayette Courts Family Development Center** provides comprehensive health care, child care, a preschool, adult remedial reading classes, parenting workshops, and a Head Start program for the residents of the complex. The Office of Employment and Development administers the project and runs a computer-based adult remedial reading program. Various other city agencies have reassigned staff to the center and provide training and staff development activities. The Baltimore City Department of Health runs an on-site health clinic and supervises medical professionals stationed there; a local high school and a local university helped design a school-age child care program.

Ground-floor apartments considered undesirable by residents became headquarters for the center. When that space became insufficient, the superintendent of the local school district, who was a member of the collaborative team, volunteered an under-utilized school located next to Lafayette Courts which was slated for demolition. The upper floors of the school now house the school-age child care and adult literacy components of the program.

FDC staff believe that the groundwork for this kind of collaboration had been laid with the creation of the Neighborhood Progress Administration (NPA) in 1984. The NPA was the blending of the Office of Economic Development, the Housing Authority of Baltimore City, and the Department of Health and Community Development. It was responsible for Baltimore City's public housing, employment and training, community and urban development programs.

A new Commissioner of Housing, Marian Pines, was appointed to head the NPA; her previous experience in the employment and training field had taught her that, though many of the residents of public housing projects qualified for a wide array of public programs, barriers such as transportation and child care kept them from participating. Pines understood the necessity of linking key agencies and worked to involve the heads of these agencies in developing and launching the program.

Under a subsequent administration, the NPA was dissolved, and the Housing Authority and the Department of Health and Community Development were once again independent agencies. However, the dissolution did not affect the FDC as the groundwork had been laid by a small task force of NPA officials in 1986. The agencies continued to work together to serve the same clients, and Lafayette Courts FDC was born.

Along with contributions from each participating agency, the program is supported by federal Community Development Block Grant funds. A U.S. Department of Labor grant supports the collaboration's administrative operations.

New Beginnings

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New Beginnings, developed by dynamic and energetic administrators from local social service and education agencies, is a comprehensive service project in San Diego, California, located adjacent to Hamilton Elementary School in a low-income area of the city. The center offers a wide array of services to children and their families, including health care, social welfare services, counseling and referrals for employment training. All families visit the center for school registration and are automatically introduced to the services available there.

The keystone of the New Beginnings design is case management. Family Service Advocates, who are reassigned line workers from local social service and health agencies, are stationed full-time at the center. Although paid through their home agencies, these providers have caseloads exclusively made up of families from the Hamilton attendance area. They meet regularly as a team to discuss policy and individual cases. Though not included in these particular meetings, families are involved in their own case planning, as well as some operating decisions for the center. The program has received attention for its extensive feasibility study; planners used foundation funding to conduct a needs assessment, station a pilot Family Services Advocate (FSA) at the school, and determine the most effective strategies for improved service delivery. The FSA advocates for the family's needs with various agencies. This includes direct counseling, helping family members access services, planning, and some referrals.

Beethoven Project

Another high-profile example of comprehensive services is the Center for Successful Child Development (CSCD), commonly known as the Beethoven Project. The center occupies 10 renovated apartments in Chicago's Robert Taylor Homes, a public housing project with a high level of poverty and crime. The program began in 1986 with one service – home visiting by para-professional community residents. Today, the center provides intensive services for preschool children and families, including primary health care, Head Start and full-day child care for children three months through five years, a drop-in counseling center, psychological consultation and case management services. Its goal is to reach children before they exhibit the effects of their troubled environment and to prepare them for school. Identification of children begins before they are born through outreach to pregnant women.

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The initial experiences of the Beethoven Project illustrate an important aspect of collaboration. One of the goals of the project is to help parents by helping their children. However, program planners underestimated the need to provide or to facilitate the provision of direct services to the mothers. Substance abuse counseling and treatment, mental health services, employment training and remedial education are important needs in this largely isolated and underserved community. Staff have learned that participants more effectively follow through and utilize services at one program site ("one-stop shopping"). Though the program specifically tried to connect with its clients by hiring and training residents of the housing project to serve as home visitors, they found women initially unenthusiastic about the program and unwilling to even let the visitors into their apartments. Now, parents are involved at every level of program planning through a Community Advisory Council and a variety of informal center-based activities. After making adjustments in its structure and outlook to address the mothers' needs more directly, the project has achieved greater success.

Researchers currently are conducting a retrospective analysis which will document the impact of CSCD on families who have participated in the program from one to five years and identify those factors that enhance the capacity of families to promote early learning development of their children. The report will be available in summer 1992.

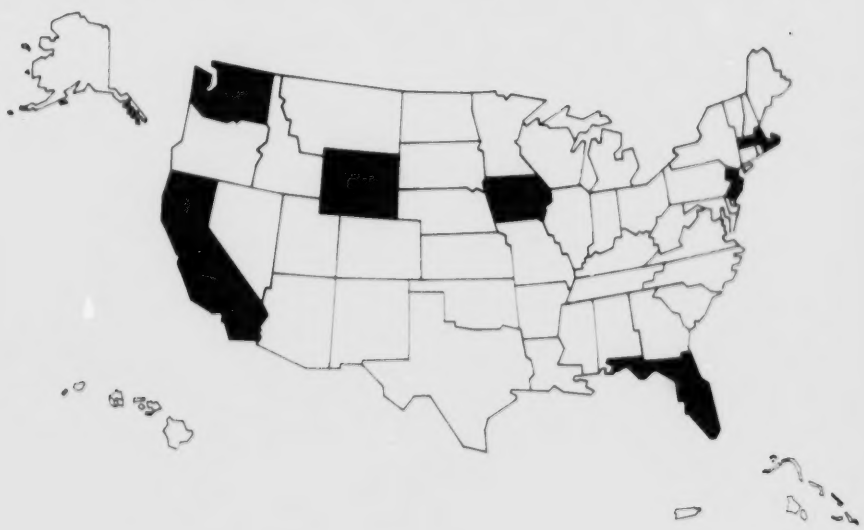
COLLABORATION IN ACTION: STATE PROGRAMS AND POLICIES

In some ways, state policymakers are in the ideal position to facilitate collaboration. They have access to and influence with both local and federal policymakers. Collaboration is on the agenda of many governors and state legislatures. The projects included here are from a sample of some states' activities, all of which are in varying stages of implementation.

Action at the State Level

Program	Location	Target Group	Purpose	Funding
Governor's Children's Agenda	California	Children and mothers	Improve services for children through interagency collaboration	State funds
School-Based Youth Services Program	New Jersey	Adolescents	Provide comprehensive preventive services at school sites	State funds + local funds
School-Based Health Centers	Massachusetts	Adolescents	Provide school-based services for adolescents	State funds
Joint Interagency Agreement	Florida	Infants and children	Mandate collaboration between the health and education agencies	State funds
Decategorization	Iowa	Children	Give local policymakers more flexibility	No new funding
Child Development Coordinating Council	Iowa	Preschoolers and families	Award grants to communities for comprehensive preschool programs	State funds
Family Policy Council	Washington State	Children and families	Improve services through family-focused, locally planned approach	State funds
Governor's Initiative	Colorado	Children and families	Reform and restructure health and human services	State funds

Good health is a significant determinant of a child's ability to learn and succeed in school.



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The Governor as Initiator

In "Breaking Down the Barriers," the National Governors' Association points to the governor as the "chief architect, chief executive, and chief communicator" of a state's policy towards children and families. Many governors and state legislatures have taken on children's issues as a major priority. Three states in particular are reshaping the way services are delivered to children and their families, California, Colorado, and Washington. Though the programs are not at the full implementation stage, they are proposing changes which may, in the long run, facilitate collaboration. In all three instances, the governors have taken the lead in initiating dialogue and planning.

California

Newly-elected Governor Pete Wilson's first act in office was the creation of a new Cabinet-level post, the Secretary for Child Development and Education. The new secretary and her staff were charged with developing and overseeing a comprehensive, coordinated effort to improve services for children in California, with an emphasis on preventive programs and expanded access for disadvantaged populations.

Healthy Start

One element of the governor's agenda for children is the inclusion of all eligible four-year-olds in the state's preschool programs, modeled after Head Start. The governor more than doubled the funding for the program by allocating $45 million more in state funds to serve an additional 21,000 children. The plan also allocates $20 million to create the **Healthy Start** program, through which schools plan and implement "one-stop shopping" centers that integrate health and social services at school sites. Healthy Start also requires state agencies to administer the program jointly, thereby encouraging interagency collaboration and coordination. The plan allocates $10 million for early mental health counseling at the school site to help children with minor problems before they become major barriers to success. The governor also proposed and signed legislation providing $53 million to improve access to prenatal care.

Interagency Council

Another state-level collaboration is the **Interagency Council** on Child Development, which was created by the governor. The council brings together high-level officials in the state administration to facilitate interagency coordination and to develop a long-term plan for better serving California's children. Chaired by the Secretary of Child Development and Education, the council includes top-level representatives from all state agencies that affect children's lives, including the departments of health and welfare; education; finance; business, transportation, and housing; youth and adult corrections; planning and research; as well as the Office of the Attorney General. The governor has delegated to these officials, all of whose agencies affect some aspect of children's policy, the authority to waive certain state requirements to facilitate collaboration. The Council has one year to develop its plan.

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Colorado

Health and Human Services Reform and Restructuring

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Using Ford Foundation funds administered through the Council of Governors' Policy Advisors, Colorado has designed a plan to reform and restructure the state's health and human services. The plan is coordinated out of the governor's office by the deputy director of policy. Through a cooperative planning process, the key stakeholders (policymakers, managers, funders, service providers, and consumers) identified 17 principles to guide reformers in Colorado's health and human services system. Strategies to reorganize these state agencies have been developed, and legislation has been introduced to set this change in motion. Stakeholders include health, education, welfare and other human service agencies, private agencies, corporations, and public and private hospitals.

One facet of this strategic plan is the provision of incentive grants to neighborhood-based family centers. These centers will provide families in at-risk communities with comprehensive, intensive, integrated, and community-based services at a single entry point. All families within the community may use the resources, regardless of income status. Care services to be offered through family centers will range from early childhood care and education to well-child care checkups and basic health services, with the overall focus being family preservation and family partnerships with health and human service providers. The request-for-proposals process for the family centers encourages schools to be the developer of a center for a community. In some places, schools will be the lead agency that pulls the different groups together to respond to the RFP. This neighborhood-based approach is expected to improve outcomes for children and families by the year 2000.

Washington State

Family Policy Council

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In 1989, at the invitation of the Council of Governors' Policy Advisors, the lead staff of several state agencies attended a Family Academy focusing on how the state responds to children and families at risk. As a result, the governor and the state superintendent of public instruction authorized an interagency agreement to coordinate the services of five state agencies (education, health and social services, community development, employment security). The goal of the agreement is to improve services for children and their families through a family-focused and locally planned approach.

The Family Policy Council is the governing body for the plan, which is in the process of formulation. It consists of 15 individuals, with a core group made up of the CEOs of the five agencies and a representative from the governor's office. The council meets monthly to oversee the planning and implementation of the initiative. The council recently completed an external scan of the state environment through focus groups to test the principles proposed to guide the coordinated approach. It is currently running an internal scan, meeting with agency employees for their input. Out of this internal and external process, the council will modify its vision for implementation. Funding mechanisms are still being "hammered out." The primary focus of the Council is to design and implement a plan by which agencies can jointly conduct their business more effectively with existing funds. However, this does not preclude the possibility of asking for additional funds or posing legislation in the 1992 legislature, if necessary.

During the planning phase, the council is sponsoring several pilot projects across the state to test the proposed operating principles. The superintendent of public instruction is working with 15 school districts to develop family support teams through Chapter 1 funds. These teams are headed by a case worker on site who manages the support team for each family. Other pilot efforts include a "seamless" childcare network in four communities and a comprehensive integrated teen parenting model.

States Creating the Environment for Collaboration

One role of state government is to provide credibility, stability, and financial support for a network of local programs. Through their efforts, state-level policymakers can promote the idea of collaboration, disseminate information about successful strategies, and establish incentives for local providers willing to initiate collaborative programs. A statewide framework can reduce the isolation of individual programs and increase the staying power of innovative ones.

New Jersey

School-Based Youth Services Program

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The **School-Based Youth Services Program (SBYSP)** is one of the most comprehensive state-level collaborative efforts in the nation. Funded through the state budget with a local match, the SBYSP has established full-service centers in 29 high schools and seven middle and elementary schools. Each site must choose a lead agency, form a Community Advisory Board, and delineate the contributions of each participating agency. All programs are jointly sponsored, through written agreements, by local school districts and community agencies.

The managing agency can be any school, government, or non-profit community-based agency or organization. All sites, located at or near school buildings, provide direct health services, substance abuse counseling, recreational activities, job and employment training, and mental health and family counseling. Each has a direct connection with a doctor, nurse, and/or hospital, and some have a full-time nurse practitioner on staff at the center. The centers remain open during and after school hours and during the summer. Some are open on weekends.

The centers are open to all students, not just those designated as "at risk" or "special needs." This policy has helped remove the stigma that other centers face and encourages widespread use among high school students. The popularity of the centers among students and the availability of recreational activity increases the likelihood that professional staff can reach students **before** they get into trouble — before pregnancy, drug abuse, or self-destructive behaviors.

The SBYSP was created by the Commissioner of Human Affairs and the Director of Legal and Regulatory Affairs. These two state-level administrators asked teenagers around the state what they needed and wanted, making the SBYSP an instructive model of multi-level collaboration that started at the top but was given flexibility to develop locally. The Department of Human Services developed the program in cooperation with the Departments of Education, Health and Labor. The Department of Human Services then mandated local collaboration by hinging state funding on evidence of collaboration. Local officials and service providers responded to this example, revamping their administrative and service delivery systems to conform to the tenets of the SBYSP and developing meaningful collaborative relationships. Additionally, flexibility to provide services such as day care, tutoring, team parenting, transportation, and family planning was allowed as a local option.

The SBYSP receives $6 million per year from the state budget, with an average of $200,000 per site. (An additional $500,000 was recently included in the budget to fund a pilot program for middle and elementary schools.) Each site is required to provide a 25

percent matching contribution, either through cash or in-kind services or facilities. Supplemental funding comes through existing programs. For example, the Department of Human Services will assist schools serving Medicaid-eligible students to become certified as Medicaid providers and receive reimbursement for services rendered to those students. The leadership of non-profit agencies has proven especially valuable in developing the centers. These agencies are accustomed to dealing with different systems in order to deliver services and are able to provide the flexibility needed for more efficient operations.

Under this program the rural **Pinelands Regional High School** has demonstrated success in reducing teen pregnancy. The year before the center opened, there were 20 pregnancies among the students; one-fourth of the babies were low birthweight. The center's first year saw 13 pregnancies, with all babies born at full weight and all mothers staying in school. The next year, there was one pregnancy. This center also had a reduction in the student suspension rate from 320 in 1989 to 78 in 1990. The program, like others in the state, emphasizes health education, preventive care, and keeping at-risk students in school.

Massachusetts

Re-allocating Adolescent Health Funds

The Massachusetts Department of Public Health in the late 1980s found itself spending nearly $2 million on underutilized adolescent health clinics located in medical institutions. Under the direction of the Deputy Commissioner for Health Promotion in the Bureau of Parent, Child and Adolescent Health, the department redirected $500,000 of these funds to support 11 school-based health clinics throughout the state. Some of the funded sites already had health clinics, though many of those lacked a stable source of funding. Each site received between $40,000 and $50,000 of state money, which constituted from one-third to one-half of their budgets.

The key to the state plan was reallocating existing adolescent health funds, rather than the creation of new sources of funding. It was clear that locating centers in schools would be a more efficient and effective way to reach adolescents with state health dollars than continuing to rely on existing state clinics. Though the state contribution did not cover even one-half of the cost of operating the clinics, it gave credibility to the effort and leveraged additional funding from other sources, public and private. The style of the decision helped diffuse opposition. State officials handled the reallocation issue internally before publicly announcing the policy shift.

In Holyoke, an economically depressed city in western Massachusetts, the state played a major role in fostering collaboration in several ways. A grants announcement from the state Department of Health led to the creation of an **Infant Mortality Task Force**. The collaboration of health providers and early childhood educators helped reduce the infant mortality rate in Holyoke from first to 16th in the state. The success of this effort fueled the formation of the **Holyoke Primary Care Task Force**, a group of health and education providers that meets monthly to identify problems and possible causes and to develop solutions. The **Holyoke System** for Pregnant and Parenting Teens is another example of sustained collaboration.

One result is a common form that helps all agencies involved with pregnant and parenting teens to share information. The **Holyoke School-Based Health Center** grew out of these earlier collaborations. A nurse practitioner began to work with a classroom

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teacher at the high school to establish a center to serve adolescents. Though the center opened before the state's reallocation, the added funds and support greatly enhanced its capacity. Betty Bradley, the classroom teacher who initiated the effort, believes that along with state support, one factor in the success of community collaboration was the publicity surrounding the problems in the community. High infant mortality and teen pregnancy rates, announced by the state and picked up by local media, pushed health and education providers to develop more effective programs, resulting in the "marriage" of the two systems.

FLORIDA

INTERAGENCY AGREEMENT

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A joint agreement signed by the Commissioner of the Department of Education (DOE) and the Secretary of the Department of Health and Rehabilitative Services (HRS) commits each to develop and support joint program initiatives. These must facilitate the provision of a comprehensive system of care which meets the health, educational, vocational, social, and mental health needs of Florida's children and youth. The agreement specifies that the two agencies will collaborate on all matters relating to school health, the implementation of P.L. 99-457 for children from birth to five years old, dropout prevention, developmentally appropriate day care for the children of teen parents, AIDS issues, public/private partnerships, and parent education and involvement programs. Joint work groups stemming from the agreement have focused on the implementation of P.L. 99-457 for infants and toddlers with special needs and on drug-affected infants. A statewide conference on "Hot Topics: Understanding Substance-Exposed Children in the Classroom" brought local health providers and educators together to develop collaborative programs.

In June 1990, the Florida legislature enacted the Supplemental School Health Services act. The legislation requires that school districts develop and implement supplemental school health services projects aimed at reducing teen pregnancy and establishing full-service school-based health centers. A joint committee appointed by the Commissioner of Education and the Secretary of the Department of Health and Rehabilitative Services (HRS) is responsible for selecting the applications to be funded.

The first-year funding ($2.6 million) allowed HRS county public health units together with local school districts to fund 28 school health services projects in Florida. These projects provide access to health services to over 93,000 students in the state. In the second-year funding ($9 million) Florida provided annual funding for the original projects and added 21 new projects. The combined awards total $11.7 million and fund 49 school health services projects in 37 counties serving 148,242 students in 192 schools.

Supplemental services provided by these collaborations include case management for high risk students; identification and follow-up of chronic health problems; individual and group counseling; enhanced screenings and health consultations; an expanded health education effort; and locally designed activities to improve overall student health, safety, and to decrease teen pregnancy.

The legislation enables professionals from HRS and DOE at the state and local levels to work together to provide support, technical assistance, and guidance to these projects and ensure that services meet the identified needs in ways most suitable to the local community.

Healthy Kids Corporation and the School Enrollment-based Health Insurance

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Through a combination of state and federal funding, the corporation will provide up to $4.4 million in the first operational year to subsidize insurance premiums for children from low-income families. Funding for the three-year operational period is approximately $15 million. Enrollment in the program began in February 1992 in Valusia County, Florida. The county has approximately 9,000 uninsured children who are eligible for a subsidized health insurance plan because the income levels of the families are not low enough to make them eligible for public support, and commercial insurance is unaffordable.

Participating organizations and the resources they are contributing include: Florida Healthy Kids Corporation ($7 million, state revenue); Institute for Child Health Policy; Maternal and Child Health Bureau, U.S. Public Health Service ($400,000); U.S. Health Care Financing Administration ($7 million); Robert Wood Johnson Foundation ($250,000); Florida Department of Education; Florida Department of Insurance; and the Florida Department of Health and Rehabilitative Services.

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Decategorization

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The state of Iowa has launched several collaborative initiatives. The **Decategorization** program is the Department of Human Services' response to a legislative mandate to reform the financing system for child welfare services. Through decategorization of state funds, 32 separate funding streams merged into one, allowing greater flexibility for local service providers to allocate these funds and make the system more responsive to the needs of children and families. Services affected by the change include state hospital care, school health, day care, social welfare services, and juvenile justice.

The four Iowa counties (Polk, Scott, Dubuque, Pottawattamie) participating in a pilot of the program have found that decategorization freed up resources through more efficient methods of program design and service delivery. The extra resources fund new programs. One of the strengths of the legislation is that each county was allowed to shape its project according to the specific needs in that county. Foundation grants fund a full-time decategorization coordinator in each county.

One administrator indicated that the program has enabled local providers to "get off the bureaucratic merry-go-round." With more state support and less red tape, he sees greater creativity in local decisionmaking. One example is a pilot project in Polk County

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called Project Success, a "one-stop shopping" program bringing health, social service, and child welfare providers into schools. The three governing agencies submitted a grant proposal for a liaison consultant position which the Danforth Foundation funded. The need emerged from the effort to decategorize services for children and make them community-based. Through this initiative, some children returned to the classroom from out-of-district residential treatment centers and need-specialized educational programs. Others, such as teen mothers, are involved in currently operating educational programs but need connected health and child care services.

In addition to serving as the case manager, trouble shooter, and problem solver for specific families, the liaison coordinates the development of educational programs for eligible children, finds the necessary resources to serve them, and works with participating agency representatives who have the same goals.

Child Development Coordinating Council

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Another statewide collaborative effort supporting the health, education, and development of young children is the **Child Development Coordinating Council**. Legislation passed in 1988 created the council to oversee a grant program for local communities developing collaborative programs for preschool children and their families. Funded programs follow the Head Start model, providing early childhood education, health care, social services, nutritional services, and parent activities and support.

The interagency council includes representatives from the state departments of public health, education, and human services; the Commission on Children, Youth, and Families; area education agencies; universities; and parents involved with the Head Start program.

State funding for the program has increased dramatically. The current $6.125 million is more than five times the initial appropriation. In the original legislation, only three- and four-year-olds were eligible, but the scope of service has widened to include five-year-olds, parent education, and support programs for parents of at-risk infants and toddlers. A new element of the grants requires that each program use at least one percent of its budget for program evaluation. The council maintains accountability by requiring local programs to reapply for funds each year and document progress towards their stated goals. Each program is required to participate in the National Academy of Early Childhood Programs Self-Study sponsored by the National Association for the Education of Young Children.

Another initiative of the Iowa state legislature was a requirement that every school district in the state form a committee around early childhood issues. These committees were charged with conducting a year-long study of programs serving young children, focusing specifically on before- and after-school child care, preschool programs, Head Start, and parent education and kindergarten programs. The committees, representing the education, health, social service, higher education, parent, and business communities, reported their findings, including recommendations for state action to improve services for children and families, to the state Department of Education.

Many of these committees are still in place around the state, though there is no longer a legislative mandate for their existence. The Department of Education, state legislators, and the Child Development Coordinating Council look to the local groups for

advice and guidance. One reason why some committees remain active while others disappeared is the intensity of the problems in certain regions of the state. In some cases, a strong committee leader and high commitment to early childhood issues ensured the continuance of the committee.

These and other states have devised ways to help establish and sustain collaboration at the local level. The Strategic Planning Guide for the Annie E. Casey Foundation's New Futures initiative discusses the importance of a meaningful state commitment to local collaborations and provides a set of guidelines to assess the strength of the commitment. Evidence of a strong state commitment, as described in this guide, includes:

- redeployment of state and/or federal funds;
- provision of incentives for collaboration;
- use of case management;
- creation of a combined budget for children/youth programs;
- dissemination of information on children's issues and services; and
- collaboration among state-level policymakers.

State policymakers wanting to foster collaboration and attain the National Education Goals by the turn of the century have good examples to follow. Just as the Family Support Act drew from state experiences with innovative welfare reform efforts, so the acceptance of thoughtful, strong collaborations in health and education can build on knowledge gained from the early risk takers.

COLLABORATION IN ACTION: THE FEDERAL ROLE

Though furthest removed from the children and families its policies and programs affect, the federal government can play a major role in facilitating collaboration between the health and educatio systems. Some federal programs, such as Head Start, established mod for collaboration years ago. Along with allocating funds, the federal goverr ment can give legitimacy to collaboration and lead public opinion to support i Federal programs themselves can also have significant effects: participation in the Special Supplemental Food Program for Women, Infants, and Children (WIC improves the development of preschool children and reduces premature births by 15 to 25 percent.

Recent action at the federal level includes the creation of a "mega-agency" in the Department of Health and Human Services to serve children and families The new entity is led by an assistant secretary with a budget of $27 billion in funds for pre-existing programs. In another initiative, the Departments of Education and Health and Human Services are collaborating around the first of the National Education Goals, preparing all children to start school ready to learn. One product of the collaboration to date was a jointly-sponsored conference. The Surgeon General has launched an initiative called "Healthy Children Ready To Learn" to lead the health community's efforts to achieve the readiness goal. HHS will sponsor a multi-million dollar grant program: Healthy Start, to improve prenatal care and child health; 15 pilot projects in urban and rural centers that integrate expanded prenatal care; teen pregnancy prevention; substance abuse treatment; and infant mortality prevention through health/ education collaboration. These will receive funding beginning in fiscal 1992. One U.S. senator has called for "Social Security for Children," providing coordinated comprehensive services and funding for children and youth as an entitlement.

HEAD START

The **HEAD START** program is the best-known federal example of collaboration. Originally offered as part of the War on Poverty in the 1960s, the Head Start program now distributes $2.4 billion annually to fund preschool programs for disadvantaged children; that amount will increase in each of the next several years. Head Start differs from most other federal programs in its comprehensiveness. Programs include a variety of health and social services as well as a developmentally appropriate curriculum for four-year-olds.

Head Start is almost universally lauded as an example of how successful the federal government can be in mandating collaboration and emphasizing comprehensive services. The major problem has been lack of access; only one in four eligible children is actually enrolled in a Head Start program. Recent federal initiatives have provided the largest funding increases in the history of Head Start. Another priority is to encourage greater collaboration between Head Start and public schools in order to sustain the gains children make when participating in the preschool program.

In its recent report "Beyond Rhetoric," the National Commission on Children recommended that "all children, from the prenatal period through the first years of life, receive the care and support they need to enter school ready to learn — namely, good health care, nurturing environments, and experiences that enhance their development." As a part of the Commission's recommendations and in response to both Head Start's success and its limited access to eligible children, the report urged that the program be "available to every income-eligible child in the United States."

INDIVIDUALS WITH DISABILITIES EDUCATION ACT, PART H

The **INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA)**, formerly the **EDUCATION FOR ALL HANDICAPPED CHILDREN ACT**, guarantees a free and appropriate education (FAPE) for handicapped children with special educational needs. It was amended in 1986 by Public Law 99-457 to include children under the age of five. Children from three to five years of age were made eligible for FAPE under the Preschool Grants Program (Section 619, Part B), while Part H of the new law established a statewide comprehensive system of early intervention services for infants and toddlers. Part H requires service providers to develop a family-centered, multi-disciplinary Individualized Family Service Plan for each child and family served, following an interagency planning process. The number of young children and families served under the Act has increased significantly since the passage of the new amendments.

CHILDREN SERVED BY IDEA

	Birth to 3 years old	3 to 5 years old
1985	36,000	260,000
1991	247,477[8]	362,527

Source: Thirteenth Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act, 1991, U.S. Department of Education.

[8] Data reported by Part H should be interpreted with caution as it does not represent a clearly unduplicated or comprehensive count. Data reporting systems are just beginning to become operational.

The Preschool Grants Program has been extremely successful in meeting the mandate of PL 99-457. Buoyed by a bonus incentive program, all states enacted enabling legislation; all states except one began full implementation in the fall of 1991, the original target date.

Under Part H, states experienced some problems as they implemented the program due to fiscal constraints and the complexity of developing interagency agreements.[9] Funding levels have been lower than originally anticipated, leaving states to foot more of the bill. The timeframe for implementation has been challenging, particularly for financially strapped states and/or those that had not instituted a collaborative planning process before the legislation. In June 1991 Congress extended the time period for phasing in Part H by up to two years by adding a provision for "differential participation." As a result, 11 states opted for "differential participation," and all other states are presently working towards meeting the original requirements.

Challenges faced by the states include: 1) cross-agency regulatory inconsistencies, e.g., Medicaid categorical funding as applied to early intervention services; 2) staff shortages; and 3) a lack of collaborative leadership development. Also, because states may define eligibility criteria and are not required to serve children who do not meet those criteria, certain populations are left unserved. This is particularly true for at-risk children.

The lesson of the P.L. 99-457 experience seems to be that the federal government must provide leadership in interagency initiatives and support that leadership with adequate resources. The legislation has spurred state and local efforts to serve more children and families. However, its failure to provide enough funding, a realistic time line, waivers for regulatory restrictions, and pooled funding has hampered state and local providers in their efforts to implement new programs.

South Dakota is an example of a state that has developed a comprehensive program to implement the new amendment. Its interagency plan is particularly notable for its effort to ensure services for the sizable, underserved Native American population in the state. Likewise, Hawaii and Connecticut have developed comprehensive programs to serve high-risk children.

MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROGRAM

For many children, the **MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROGRAM (EPSDT)** is their only access to medical services. Though underutilized and plagued by implementation problems, the EPSDT program presents a ripe opportunity for more collaboration. EPSDT covers children through age 2; virtually any Medicaid-eligible child whose problem is diagnosed and recorded as a part of an EPSDT screen would continue to be eligible for needed treatment throughout his/her school career at Medicaid's expense, as long as his/her family continues to qualify for Medicaid.

The program provides primary and preventive health care for children eligible for Medicaid services. Increased use of the EPSDT program by all health care providers serving Medicaid-eligible patients could detect problems for a majority of low-income children early and arrange for needed treatments and interventions. This could include such items as eyeglasses and hearing aids, physical therapy, dental care, speech, language or hearing therapy, inpatient psychiatric care, rehabilitative services, and a variety of other needed services.

Clearly this is a program which child care and school officials can tap. If a child exhibits developmental delays or problems—physical or mental—school personnel could provide a referral to a health care provider who will conduct an EPSDT exam and arrange

[9] Brown, C. (1991). "State Delays in Part H Phase-In," *Early Childhood Reporter*, LRP Publications, Alexandria, VA, March.

for needed treatment. It is a benefit to the parents and the child that this exam be done as part of the EPSDT program because the child will be eligible to receive an expanded menu of treatment.

While not all administrative obstacles have been removed, amendments to the program by the Omnibus Budget Reconciliation Act (OBRA, 1989) increased the number of preschool children eligible and required states to fund any treatment necessary for health problems diagnosed through EPSDT, regardless whether a state currently covers that service under its Medicaid program. In addition, the OBRA of 1990 increased the number of children eligible for Medicaid and the EPSDT program. These additions have the potential to expand care significantly for infants and children, including pregnant adolescents. The amendments also addressed "periodicity" schedules. These identify the frequency with which a child can receive a medical or dental exam. The amendments mandated to pay for interperiodic EPSDT exams as necessary; eliminated the exclusion of eening providers who are unable to furnish the entire health exam; and provided of medically necessary diagnostic and treatment care.

Though underutilized and plagued by implementation problems, the EPSDT program presents a ripe opportunity for more collaboration.

Problems at the state level have limited the effectiveness of the amendments in practice. Insufficient numbers of Medicaid providers and particularly EPSDT providers is one problem. Another is the limited range of care available at most health treatment centers. Furthermore, in the midst of budget crises, many states are looking for ways to contain and/or cut their Medicaid costs because Medicaid is one of the fastest rising expenditures in the budget. This means that states are hard pressed to bring on more EPSDT providers because this will ultimately mean an increase in Medicaid claims as well as the need for more technical assistance to these new providers. State governments are also reducing their own staffs, which often limits availability and assistance from state Medicaid personnel.

For example, most school health services do not have the budgets to hire non-medical personnel who know how to bill and file claims and understand the forms required for reimbursement by the state. Such dilemmas could be addressed by a pooling system where bills from several schools providing EPSDT services are managed from one central place with the needed expertise. Unless a state has made the school/EPSDT interface a priority, some state Medicaid offices simply do not have the resources to provide the assistance needed to certify and service non-traditional providers, such as schools.

Yet, there are encouraging signs in several states. Strong legislative and executive branch action indicates renewed interest in schools becoming EPSDT providers. California's SB 620, signed in October 1991, has opened the door for new certification for schools as Medi-Cal providers. In Oregon there has been strong legislative support for reimbursement through a combination of EPSDT and Medicaid. Schools in other states such as Louisiana, Kansas, New Hampshire, North Dakota, Connecticut, Minnesota, Michigan, and Arkansas are also billing EPSDT and/or Medicaid for reimbursement of services.

Massachusetts, West Virginia, and Louisiana schools already are billing Medicaid under EPSDT for the costs associated with Individual Education Plans (IEP) required under Part B of PL 99-457. Missouri, for example, is currently working on a three-pronged approach to tap EPSDT's potential. One is to certify ancillary special education providers, such as speech therapists and pathologists, physical therapists, and occupational therapists. Secondly, a new screening package allows schools to be EPSDT screeners with broader allowances for personnel performing partial screens. This enables a wider range of personnel to do eye and hearing screens, whereas medical personnel provide unclothed physical screens.

Finally, Missouri is piloting an EPSDT program where 130 staff are involved in preparing a monthly time log. School staff does EPSDT administration, which includes outreach, coordination, and the development of an interagency agreement with the school district under which the school can file claims. It was discovered that 20 percent of accountable staff time resulted in a substantial claim to Medicaid. The goal for other sites would be an interagency agreement with a school system where the school does the EPSDT screen, evaluation, case planning and coordination. These kinds of results encourage school systems to increase their involvement in providing health services on site.

In South Carolina, policymakers have used the EPSDT provisions to increase collaboration between health and education services. Along with increasing the number of certified providers in the state, policymakers also developed a home-visiting program to inform women of available services and enroll their infants and children in the program. The agency responsible for overseeing Medicaid in the state has implemented reforms designed to enhance interagency cooperation and provide more comprehensive services to children and families participating in the EPSDT program.

The federal government could work with the states to see that all children eligible for EPSDT receive the services they need and encourage additional providers, including schools, to become certified to administer EPSDT services.

Conclusion

The challenge is clear. At every level — local, state, and federal — policymakers must take swift and sure action to remove the barriers to health/education collaboration. We must provide incentives for collaboration, resources to fund collaborative initiatives, and support for the front-line providers whose solutions "trickle up" and make a positive difference in the lives of children and families. This, after all, is our common goal, and our ability to achieve it depends on our commitment to working together.

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National Health/Education Consortium

Good health is a significant determinant of a child's ability to learn and succeed in school. The health and education sectors, however, have historically approached programs and services for children from different perspectives. Recognizing the need for better integration of health and education programs for children, the National Commission to Prevent Infant Mortality and the Institute for Educational Leadership organized the National Health/Education Consortium.

The project has brought together leaders from 51 national health and education organizations, representing nearly 11 million constituents, to bridge the separate worlds of health and education into unified action for children. Promoting the full potential of children and providing them with the best opportunities for success will require changes in the systems which currently provide health and education services. Reforms are needed to develop more collaborative and cohesive policies, unify agencies and funding streams, and provide a more comprehensive approach to children's programs.

The Consortium's activities focus on three major goals: to improve public policy in addressing the need for a better coordinated health and education delivery system; to strengthen communication and dissemination of information between health and education programs and policymakers; and to identify exemplary program models and practices which integrate health and education. Toward this end, Consortium members are working to identify a series of action steps to implement these objectives at the federal, state and local levels. The Consortium will be involving educators, health professionals, policymakers, administrators, advocates and parents in its efforts to bring together the health and education communities in a more integrated fashion.

The National Health/Education Consortium began in May 1990. The foundation of the Consortium's efforts can be found in the report, Crossing the Boundaries between Health and Education, which documents clinical research and programs that exemplify the relationship between children's health and their learning potential. To complement this report, the Consortium is releasing a series of papers which focus on various topics relating to health and education.

The National Health/Education Consortium is supported by The Prudential Foundation, Honeywell, the AT&T Company, and Metropolitan Life Insurance Company. Additional support has been provided by the U.S. Department of Health and Human Services, and the U.S. Department of Education.

National Health/Education Consortium Members and Profiles

- American Academy of Family Physicians: *66,000 physicians*
- American Academy of Pediatrics: *39,000 physicians*
- American Association of Colleges for Teacher Education: *represents 700 member institutions teacher education programs*
- American Association of School Administrators: *18,517 school administrators*
- American College of Nurse-Midwives: *3,000 certified nurse-midwives*
- American College of Obstetricians and Gynecologists: *29,848 obstetricians and gynecologists*
- American Federation of Teachers: *750,000 teachers, para-professionals (teacher aides), school-related personnel, healthcare workers, federal and state employees*
- American Hospital Association (MCH Section): *5,870 hospitals and physicians*
- American Indian Health Care Association: *represents 36 programs and clinics which focus on the health care of American Indians*
- American Medical Association: *300,000 physicians*

- American Nurses Association: *201,000 registered nurses*
- American Public Health Association: *30,977 physicians, nurses, therapists, health technicians, health support personnel, and other health professionals*
- American School Health Association: *3,000 health educations, nurses, physicians, and dieticians*
- Association of American Medical Colleges: *126 U.S. medical schools, 450 teaching hospitals, and 92 academic professional societies*
- Association of Maternal and Child Health Programs: *represents directors and other key staff of Title 5 MCH and CSHCN programs and all other states and political jurisdictions.*
- Association of Schools of Public Health: *represents 13,000 deans, faculty, and students of schools of public health*
- Association of State an Territorial Dental Directors: *represents 58 state and territorial dental directors.*
- Association of State and Territorial Health Officials: *represents the 58 health officers from each of the United States and its territories.*
- Association for the Care of Children's Health: *4,200 nurses, child life workers, and parent leaders*
- Association for Supervision and Curriculum Development: *153,000 teachers, school administrators, college professors, and school board members*
- Council of Chief State School Officers: *represents 56 public officials who head departments of elementary and secondary education in each state and extrastate jurisdiction*
- The Council of Great City Schools: *represents 46 of the largest urban public school districts in the United States*
- Healthy Mothers, Healthy Babies Coalition: *represents 95 non-profit health education groups, and state and local education groups*
- NAACOG (The Organization for Obstetric, Gynecologic and Neonatal Nurses): *24,000 nurses*
- National Alliance of Black School Educators: *3000 African-American teachers for Grades K-12*
- National Association for Asian and Pacific American Education: *594 members representing administrators, teachers, institutional aids, social workers, mental health workers, and students among others*
- National Association of Children's Hospitals and Related Institutions: *represents 108 hospitals*
- National Association of Community Health Centers: *represents 600 health care facilities*
- National Association for the Education of Young Children: *77,000 members representing a wide range of early childhood professionals*
- National Association of Elementary School Principals: *36,000 elementary school principals, middle school principals, school superintendents, teachers, professors, and instructors*
- National Association of Hispanic Nurses: *1,000 Hispanic nurses*
- National Association for Partners in Education: *5,5000 volunteers, presidents and executives of private businesses, teachers, and administrators*
- National Association of Pediatric Nurse Associates and Practitioners: *2,800 pediatric nurse associates and practitioners*
- National Association of School Nurses, Inc.: *5,800 school nurses*
- National Association of Secondary School Principals: *41,000 secondary school principals, administrators, guidance counselors, activities directors, and college professors*
- National Association of Social Workers, Inc.: *137,763 members in all fields of social work*
- National Association of State Boards of Education: *represents 600 state boards of education and their members*
- National Black Nurses Association: *7,000 African-American nurses*
- National Center for Clinical Infant Programs: *represents 7,500 programs for high risk children and families, as well as individuals*
- National Coalition of Hispanic Health and Human Services Organizations (COSSMHO): *700 organizations serving the Hispanic population, representing Hispanic physicians, nurses, and students*
- National Community Education Association: *1,600 teachers, superintendents, administrators, community education directors and coordinators, faculty and administrators of teacher education institutions and programs, community activists, private businesses, and state administrators*
- The National Congress of Parents and Teachers: *6.8 million parents, K-12 classrooms teachers, principals, school administrators, and students*
- National Education Association: *2 million K-12 classroom teachers, professors, educational support personnel, and students*
- National Head Start Association: *150 nationwide agency members and 30 individual members*
- National Medical Association: *16,000 minority physicians*
- National Mental Health Association: *550 local affiliate mental health associations representing mental health care providers, clients, and community health care centers*
- National Perinatal Association: *6,000 physicians, nurses, nurse-midwives, social workers, and consumers of perinatal services*
- National Rural Health Association: represents *1,750 community, migrant, and homeless health centers and their staffs*
- National School Boards Association: *represents 52 state school board associations*
- National School Public Relations Association: *2,200 teachers, principals, administrators, retired teachers, students, and public relations personnel*
- Society for Neuroscience: *represents 18,000 neuroscientists*

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